STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #90733 and #91553. A revised copy of the 2567 was sent to the provider on 9/30/15.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

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F 157	Continued From page 1	F 157		

legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 37 residents. The sample included 4 residents. Based on observation, record review and interview the facility failed to notify the physician the facility had not received and administered medications for Resident #1, as ordered by the physician.

Findings included:

- Resident #1's admission (MDS) Minimum Data Set assessment, dated 8/5/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident received antipsychotic and antidepressive medications.

The 8/5/15 (CAA) Care Area Assessment summary for falls indicated the resident received Seroquel (antipsychotic medication) and Cymbalta (antidepressive medication).

The 7/30/15 care plan indicated the resident cognitively impaired and directed staff to administer medications as ordered.

The 7/30/15 physician's admission orders directed staff to administer, to the resident, the following medications:
Prednisone (anti-inflammatory), 5 (mg) milligram, daily.
Prilosec (decreases amount of stomach acid produced), 20 mg, daily.
Seroquel (antipsychotic), 25 mg, at bedtime.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2	F 157		

Neurontin (medication used for nerve pain), three times daily.
Maalox Max suspension (antacid), 5 (ml) milliliters, before meals and at bedtime.

Review of the (MAR) Medication Administration Record and nurse's notes revealed no documentation the resident received the following medications between 7/31/15 and 8/7/15:
Prednisone, 5 mg, 7/31/15 through 8/7/15. (8 days, 8 doses)
Prilosec, 20 mg, 7/31/15 through 8/5/15. (6 days, 6 doses)
Seroquel, 25 mg, 7/31/15 through 8/4/15. (5 days, 5 doses)
Neurontin, 100 mg, 7/31/15 through 8/4/15 in the afternoon. (5 days, 14 doses)
Maalox suspension, 5 ml, 7/31/15 through 8/7/15 at noon. (8 days, 30 doses)

On 9/16/15 at 7:30 AM, observation revealed the resident left the dining table, in his/her wheelchair and self-propelled from the dining room to his/her room.

On 9/16/15 at 5:25 PM, Administrative Nurse D verified staff had not administered the physician ordered doses of Neurontin, Prednisone, Seroquel, Maalox and Prilosec, as noted on the MAR. He/she stated the family wanted the facility to use the medications supplied by them, but kept forgetting to bring the medications to the facility. Administrative Nurse D stated staff failed to obtain the medication in a timely manner and failed to notify the resident's physician the resident had not received several doses of 5 different medications.

The facility failed to notify the physician the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3 had not received or administered to the resident, numerous doses of 5 different medications during the first week after the resident's admission to the facility.	F 157		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility had a census of 37 residents. The sample included 4 residents reviewed for accidents. Based on observation, record review and interview, the facility failed to care plan appropriate interventions to prevent further falls for 1 of 4 residents reviewed for accidents. (#1)	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 4	F 280		

Findings included:

- Resident #1's admission (MDS) Minimum Data Set assessment, dated 8/5/15, indicated the resident had adequate vision with glasses and a (BIMS) Brief Interview for Mental Status score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident independent with bed mobility, transfers, walking, eating, dressing, required supervision with toileting, and limited assistance with personal hygiene. The assessment indicated the resident's balance unstable, but he/she was able to stabilize self without assistance, had no (ROM) Range of Motion impairment, used a walker, had no history of falls prior to admission, and no falls since admission.

The 8/5/15 (CAA) Care Area Assessment summary for falls indicated the resident at high risk for falls, used a walker, and attempted to carry beverages and manage his/her walker at the same time. The summary indicated the resident walked throughout the facility several times daily, and received Seroquel (an antipsychotic medication) and Cymbalta (an antidepressive medication).

The 8/7/15 comprehensive care plan for falls stated the resident at high risk for falls related to gait, balance problems and poor safety awareness. The care plan directed staff to educate the resident about safety reminders, follow facility fall protocol, and evaluate and supply appropriate assistive devices. The 8/27/15 care plan update directed staff to ensure a safe environment including floor free of spills or clutter, adequate lighting, call light in reach, and bed in low position at night. The 9/14/15 update directed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 5	F 280		

staff to continue interventions, neurological checks, and check the resident's (ROM) Range of Motion.

The Fall Risk assessments indicated the following score guidelines: high risk= 45 and higher, moderate= 25-44, low risk = 0-24). Review of the assessments revealed the following scores for the cognitively impaired resident:
7/30/15- 55
8/6/15- 70

The 8/4/15 (PT) Physical Therapy assessment indicated the resident a high risk for falls and was frequently up, walking in the halls. The plan included restorative exercises to maintain status and improve function for (ADLs) activities of daily living.

The 8/6/15 (OT) Occupational Therapy admission screen stated the resident moved quickly and used a walker in an unsafe manner. The screen stated no alarms used for the resident, due to agitation and the resident was always on the go. The screen stated the resident reported he/she had a "crash" a while ago, that resulted in a skinned and bruised left finger. The resident reported he/she had a bad fall at home.

The 8/6/15 mobility assessment by nursing indicated no ROM impairment, moderate ability to maintain standing balance and the resident's balance not steady, but he/she was able to stabilize without assistance.

The fall report on 8/6/15 stated the resident hit his/her head when trying to get popcorn from the popcorn machine and was not using his/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 6	F 280		

walker at the time. The report stated the resident fell backwards and hit his/her head on the floor. The fall report stated the housekeeper, who saw the fall, called for a nurse to come to the dining room, where the fall had occurred. The investigation indicated the resident sustained a large bruise to the back of his/her head, with little bleeding noted, along with a 2 x 2 skin tear to his/her right 2nd finger. The report indicated staff provided wound care on the resident's head and finger wound. After the resident denied any pain, performed active ROM, the staff assisted him/her to a chair and reminded the resident (who had severe cognitive impairment) to use his/her walker and ask for help if needed.

The 8/9/15 at 2:14 PM, nurse's note indicated the resident had no changes in mental status and his/her neurological status was intact. The note stated the resident ambulated with a walker, but was unsteady, and the staff encourage the resident to slow down.

The 8/19/15 care plan conference meeting note stated the resident independent with dressing, grooming, toileting and personal hygiene. The note stated the resident independently ambulated with a walker, at high risk for falls, fell on 8/6/15, and hit his/her head. The note stated staff obtained a basket for the resident's walker to place his/her coffee cup in, and encouraged him/her to keep the walker with him/her at all times.

The 8/22/15 at 2:25 PM, nurse's note stated the staff received a phone call from the hospital staff, reporting the physician had diagnosed the resident with an acute, subdural hematoma from his/her fall on 8/6/15.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 7	F 280		

The 9/1/15 re-admission fall risk indicated high risk with a score of 105.

The 9/9/15 mobility assessment, by nursing, indicated the resident had no ROM impairment, moderate ability to maintain standing balance, and his/her balance not steady but able to stabilize without assistance.

The 9/14/15 at 9:33 nurse's note indicated housekeeper E observed the resident ambulate from his/her wheelchair to his/her bed, fall and hit his/her head on the floor. The note stated the housekeeper stated the resident was up, ambulating without assistance. The note stated the resident could not remember what he/she was doing prior to the fall, denied pain, and staff noted no injury at this time, and put alarms in place to notify staff of the resident's movements.

The 9/14/15 at 9:37 AM, nurse's note indicated staff notified the physician of the resident's fall and declining blood pressures. The note indicated at 8:30 AM the resident's blood pressure was 89/60 (optimal range is 110/70) and at 9:00 AM blood pressure was 70/55. The physician directed staff to monitor the resident and encourage fluids.

The 9/14/15 at 9:49 AM, nurse's note indicated the resident complained of his/her head hurting, but was unable to describe or rate his/her pain. The note indicated the resident refused Tylenol and stated " I think I need to see the doctor". Staff noted the resident very pale, and made an appointment with his/her physician for 11:30 AM.

On 9/15/15 at 3:44 PM, observation revealed staff brought the resident's alarm box to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 8	F 280		

maintenance person and stated the resident disabled the alarm, then walked independently to the dining room. Observation revealed staff assisted the resident to get a beverage, and then sat with him/her while he/she did an activity.

On 9/16/15 at 7:30 AM, observation revealed the resident left the dining table, in his/her wheelchair, and self-propelled from the dining room to his/her room. Further observation revealed the resident held a box of tissues in one hand and a cup of coffee in the other hand. Two staff came in to offer the resident help and 1 stayed to assist. The resident refused to allow staff to use the gait belt for the transfer, used his/her walker to stand and turn in front of the recliner. The resident stood tall with minimal unsteadiness, reached back and used the recliner arms to let him/herself down into the chair. The staff activated the chair alarm before leaving the room.

On 9/15/15 at 2:55 PM, the resident reported he/she fell when attempting to sit in the recliner without assistance. He/she stated he/she does not use the call light very much, even though staff encourage him/her to. The resident stated he/she was independent most of the time. The resident stated he/she had fallen before, but this fall hurt a lot worse, and the staff took him/her to the (ER) Emergency Room.

On 9/15/15 at 4:10 PM, Nurse G verified the resident's initial care plan had not been completed and the comprehensive care plan lacked individualized interventions to prevent further falls.

On 9/16/15 at 11:30 AM, Housekeeping Staff H

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 9	F 280		

stated he/she was in the dining room when the resident was getting some popcorn on 8/6/15. Housekeeping Staff H stated the resident was standing on a little step stool, with no nursing staff in the area, lost his/her balance and fell, hitting his/her hand/arm on the refrigerator.

On 9/16/15 at 2:00 PM, Housekeeping Staff E stated he/she was in the hall when the resident asked for some paper towels on 9/11/14. Housekeeping Staff E stated he/she heard the resident's walker fall and turned in time to see him/her on the floor, between bed one and his/her recliner. Housekeeping Staff E stated the resident had been up walking without his/her walker.

On 9/16/15 at 2:14 PM, Nurse A stated the resident was unsteady at times prior to the falls, got up without assistance a lot throughout the day, and ambulated throughout the facility with his/her walker.

On 9/16/15 at 2:40 PM, Nurse Aide B stated the resident's falls are usually in the daytime. He/she stated staff placed alarms on the resident, but the resident figured out how to turn the alarms off. Nurse Aide B stated staff had placed an alarm that did not sound in the resident's room, but went directly to the pager system. He/she stated the alarm did not sound when the resident got up independently and ambulated to the dining room, and the staff found the alarm turned off again.

On 9/16/15 at 3:00 PM, Nurse C stated the resident was independent with a walker prior to his/her fall with head injury. He/she stated the resident was very unsteady now and used a wheelchair for mobility. Nurse C stated the resident's memory poor and he/she attempts to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 10 transfer on his/her own without calling for help. On 9/16/15 at 5:25 PM, Administrative Nurse D verified the resident's care plan lacked individualized interventions for prevention of falls, on the initial and comprehensive care plans, prior to and after the resident's falls. The facility's 8/7/15 Falls and Fall Prevention policy stated a fall risk assessment form will be completed on admission, quarterly, with a significant change and with each fall and interventions deemed appropriate put into place to minimize injuries. Interventions determined to be needed are to be put in place as soon as possible to protect the resident. The MDS coordinator will update the care plan. The policy stated the care plan would be reviewed with each fall, and updated as needed. Accident/falls are to be reviewed for possible alternative safety measures by the risk manager and the director of nursing. The facility failed to provide appropriate, individualized interventions to prevent falls for Resident #1, who fell and sustained a head injury on 8/6/15, and fell again on 9/14/15.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: The facility had a census of 37 residents. The sample included 4 residents reviewed for	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 11	F 281		

accidents. Based on observation, record review and interview, the facility failed to implement interventions on the care plan to prevent falls for a newly admitted resident. (#1)

Findings included:

- The 7/30/15 initial care plan indicated the resident cognitively impaired, visually impaired, wears glasses, and required assistance with mobility and toileting, but independent with transfers, ambulation, and locomotion. The care plan stated the resident used an assistive device for ambulation or locomotion, but failed to identify what type of assistive device the resident used or any other fall prevention interventions.

The 7/30/15 nursing admission assessment indicated the resident alert to person, place and time, and had normal, but unsteady gait. The assessment indicated the resident was calm, confused, had normal (ROM) range of motion, independent with bed mobility, transfers, eating, required assistance with walking, locomotion, dressing, toileting and used a walker.

The 7/30/15 Fall Risk assessments indicated the the resident at high risk with a score of 55. (high risk= 45 and higher, moderate= 25-44, low risk = 0-24).

The fall report on 8/6/15 stated the resident hit his/her head when trying to get popcorn from the popcorn machine, and was not using his/her walker at the time. The report stated the resident fell backwards, hit his/her head on the floor and the housekeeper, who saw the fall, called for a nurse to come to the dining room where the fall had occurred. The report indicated the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

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F 281	Continued From page 12	F 281		

sustained a large bruise to the back of his/her head, with little bleeding noted, along with a 2 x 2 skin tear to his/her right 2nd finger. The report indicated after the resident denied any pain and performed active ROM, the staff assisted him/her to a chair and reminded the resident (who had severe cognitive impairment) to use his/her walker and ask for help if needed.

On 9/16/15 at 7:30 AM, observation revealed the resident left the dining table, in his/her wheelchair and self-propelled from the dining room to his/her room. Further observation revealed the resident held a box of tissues in one hand and a cup of coffee in the other hand. Further observation revealed two staff came in to offer the resident help and 1 stayed to assist. The resident refused to allow staff to use the gait belt for the transfer, used his/her walker to stand and turn in front of the recliner. The resident stood tall with minimal unsteadiness, reached back, and used the recliner arms to let him/herself down into the chair. The staff activated a chair alarm before leaving the room.

On 9/15/15 at 4:10 PM, Nurse G verified the resident's initial care plan had not been completed and the comprehensive care plan lacked individualized interventions to prevent further falls.

On 9/16/15 at 5:25 PM, Administrative Nurse D verified the resident's care plan lacked individualized interventions for prevention of falls on the initial care plan.

The facility's 8/7/15 Falls and Fall Prevention policy directed staff to complete a fall risk assessment form on admission, quarterly, with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 13 significant change and with each fall, with interventions deemed appropriate put into place to minimize injuries. Interventions determined to be needed are to be put in place as soon as possible to protect the resident. The policy directed the MDS coordinator to update the care plan. The policy stated the care plan would be reviewed with each fall and updated as needed, and accident/falls are to be reviewed for possible alternative safety measures by the risk manager and director of nursing. The facility failed to provide individualized interventions on the initial care plan to prevent falls for Resident #1, who was a high risk for falls and fell and sustained a head injury 1 week after admission to the facility.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 37 residents. The sample included 4 residents reviewed for accidents. Based on observation, interview and record review the facility failed to provide supervision and assistive devices to prevent accidents for 2 of 4 sampled residents. Resident #2, who sustained a fracture from a fall, and	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14	F 323		

Resident #1, who sustained injuries from 2 falls.

Findings included:

- Resident #2's annual (MDS) Minimum Data Set assessment, dated 5/31/15, indicated the resident's vision adequate and he/she had a (BIMS) Brief Interview for Mental Status score of 8, which indicated moderate cognitive impairment. The MDS indicated the resident experienced hallucinations (seeing objects that are not really there.) and delusions (false belief), and was independent with all (ADLs) activities of daily living. The MDS indicated the resident had no (ROM) range of motion impairment, an unsteady balance, but able to stabilize self, and he/she used a cane. The MDS indicated no falls since the prior MDS and the resident received antipsychotic and antidepressive medication.

The 5/31/15 (CAA) Care Area Assessment summary for falls stated the resident used the side rail to independently sit up on the side of his/her bed, used a quad cane, and held on to the railing in the hallway when he/she walked.

The 6/17/15 care plan for falls indicated the resident at high risk for falls and directed staff to ensure the call light in reach, encourage the resident to use it, and educate him/her about safety. The care plan directed the staff to follow the facility fall protocol, and obtain (PT) physical therapy evaluation and treatment as ordered. The care plan revealed no revisions after the cognitively impaired resident fell on 6/23/15, and complained of knee pain. The care plan revealed the following updates: 7/21/15 -15 minute checks, 8/29/15 -bed alarm initiated, 9/14/15 - The resident is currently on 15 minute bed checks and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 15	F 323		

has a bed alarm on at night.

The Fall Risk assessments indicated the following score guidelines: high risk= 45 and higher, moderate= 25-44, low risk = 0-24). Review of the assessments revealed the following scores for the cognitively impaired resident:
5/31/15 30
6/23/15 70
7/20/15 80
8/29/15 90
8/31/15 90
9/11/15 90

The 6/12/15 mobility assessment for balance indicated the resident not steady, but able to stabilize self.

The 8/20/15 PT assessment stated the resident used a quad cane, was up as desired, and at high risk for falls. The assessment indicated the resident refused to participate in therapy and directed staff to encourage the resident to participate in group exercises.

Review of the medical record revealed the resident had falls on 6/23/15, 7/20/15, 8/28/15, 9/10/15 and 9/11/15.

The 9/3/15 (OT) Occupational Therapy screen stated the resident fell on 8/28/15, and hit his/her chin. The resident stated he/she was sitting on the edge of his/her bed and fell forward. The assessment indicated the therapist spoke to the resident about using a walker and the resident refused. The therapist recommended staff keep alarms on the resident and walk with him/her, due to increased confusion and reports of weakness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16	F 323		

The 9/10/15 at 9:00 AM, nurse's note indicated housekeeping staff found the resident on the floor in his/her room. The note indicated the resident stated he/she was "going to the kitchen to help the girls", and "there is a slick spot on the floor". The resident's cane was by his/her bed, no injury noted or complaints of pain voiced, and staff notified the resident's physician and family.

The 9/11/15 at 8:58 AM, nurse's note indicated the resident was upset because he/she could not go outside to "get the boys before the police come and pick them up".

Review of the medical record revealed no interventions initiated by the staff to assist the "upset" resident.

The 9/11/15 at 11:45 AM, (2 hours, 47 minutes later) nurse's note stated a (CNA) Certified Nurse Aide witnessed the resident lose his/her balance and fall to the right as he/she stood up from the bed, fell and bumped his/her head on the wall. The note stated the resident complained of pain in his/her right groin area upon standing and with taking a step and when the nurse asked the resident to bend his/her knee. The note stated the resident denied pain when asked, refused pain medication, but facial grimacing indicated he/she was having pain. The nurse's notes indicated the staff obtained a physician's order to obtain x-rays and the facility transported the resident to the hospital for x-rays. The notes further indicated, at 2:15 PM, the nurse received a report the resident had a right hip fracture.

Review of the September 2015 15 minute visual check documentation indicated staff had not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17	F 323		

checked the resident between 10:49 AM and 11:45 AM.

On 9/16/15 at 2:14 PM, Nurse A stated the resident is at high risk for falls and forgets to use his/her cane at times, ambulated all over the facility, and "looks for little kids he/she has seen". Nurse A stated the resident fell on 9/10/15 in his/her room by him/herself, and again on 9/11/15, while being assisted by staff. Nurse A stated the resident "tripped over his/her feet" and complained of pain in his/her right groin so staff sent the resident to the hospital for x-rays.

On 9/16/15 at 2:40 PM, Nurse Aide B stated the resident attempted to be independent, lacked safety awareness, and had hallucinations and delusions. He/she stated the resident walked with a cane, and had an odd gait, but was fairly steady. Nurse Aide B stated the resident refused assistance.

On 9/16/15 at 3:00 PM, Nurse C stated the resident ambulated independently with a quad cane. Nurse C stated after the resident was in the hospital, staff walked with him/her until the resident got his/her strength back. Nurse C stated the nurse aide was with the resident when he/she fell and broke his/her hip. Nurse C stated the resident was becoming more unstable with walking and had more hallucinations. Nurse C stated each fall seemed to be related to finding "the children or family" and it was hard to re-orient the resident away from his/her delusion.

On 9/16/15 at 5:25 PM, Administrative Nurse D stated the staff documented the 15 minute checks and provided documentation. (Further review of the documentation revealed inaccurate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18	F 323		

checks) Administrative Nurse D stated the resident had hallucinations that upset him/her at times and one fall occurred when the resident was looking under his/her bed "for the children". Administrative Nurse D stated the facility did not have a policy related to visual or safety checks. He/She stated the resident was still in the hospital related to a fall, with hip fracture, on 9/11/15. Administrative Nurse D verified the lack of visual checks in the hour prior to the resident's fall.

The facility's 8/7/15 Falls and Fall Prevention policy stated a fall risk assessment form will be completed on admission, quarterly, with a significant change and with each fall with interventions deemed appropriate put into place to minimize injuries. The Post Fall assessment is to be completed with any witness information for possible causes. Interventions determined to be needed are to be put in place as soon as possible to protect the resident. Document the interventions in the nurse's notes and communicate to the next shift by the 24 hour report sheet. The MDS coordinator will update the care plan. The policy stated the care plan is reviewed with each fall and updated as needed. Accident/falls are to be reviewed for possible alternative safety measures by the risk manager and DON.

The facility failed to provide adequate supervision for Resident #2, with documentation of 15 minute checks as care planned. Resident #2 fell and sustained a fracture while staff were in the room, but not visually observing the resident.

- The 7/30/15 nursing admission assessment for Resident #1 indicated the resident alert to person,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19	F 323		

place and time, and had normal, but unsteady gait. The assessment indicated the resident was calm, confused, had normal (ROM) range of movement, independent with bed mobility, transfers, and eating; required assistance with walking, locomotion, dressing, toileting and used a walker.

Resident #1's admission (MDS) Minimum Data Set assessment, dated 8/5/15, indicated the resident had adequate vision with glasses and a (BIMS) Brief Interview for Mental Status score of 5 indicated the resident had severe cognitive impairment. The MDS indicated the resident was independent with bed mobility, transfers, walking, eating, dressing, required supervision with toileting, and limited assistance with personal hygiene. The assessment indicated the resident had unstable balance, but was able to stabilize self without assistance, had no ROM impairment, used a walker, had no history of falls prior to admission, and no falls since admission. The MDS indicated the resident received antipsychotic and antidepressive medications, and (PT) Physical Therapy.

The 8/5/15 (CAA) Care Area Assessment for falls indicated the resident was at high risk for falls and used a walker. The resident attempted to carry beverages and manage his/her walker at the same time. The summary indicated the resident walked throughout the facility several times daily, and received Seroquel (antipsychotic medication) and Cymbalta (antidepressive medication).

The 7/30/15 initial care plan indicated the resident was cognitively impaired, visually impaired, wore glasses, and required assistance with mobility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 20	F 323		

and toileting. The resident was independent with transfers, ambulation, and locomotion. The care plan stated the resident used an assistive device for ambulation or locomotion, but failed to identify what type of assistive device.

The 8/7/15 comprehensive care plan stated the resident at high risk for falls related to gait, balance problems and poor safety awareness. The care plan directed staff to educate the cognitively impaired resident about safety reminders, follow facility fall protocol, and evaluate and supply appropriate assistive devices. The 8/27/15 care plan update directed staff to ensure a safe environment including a floor free of spills or clutter, adequate lighting, call light in reach, and bed in low position at night. The 9/14/15 update directed staff to continue interventions on the at risk plan, neurological checks, and check ROM.

The Fall Risk assessments, dated 7/30/15 and 8/6/15, indicated the resident was at high risk for falls.

The 8/4/15 (PT) Physical Therapy assessment indicated the resident was a high risk for falls and frequently up, walking in the halls. The plan included restorative exercises to maintain status and improve function for (ADLs) activities of daily living.

The 8/6/15 (OT) Occupational Therapy admission screen stated the resident moved quickly and used a walker in an unsafe manner. The screen stated no alarms used due to agitation and the resident always on the go. The screen stated the resident reported he/she had a "crash" a while ago, that resulted in a skinned and bruised left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 21	F 323		

finger. The resident reported he/she had a bad fall at home.

The 8/6/15 mobility assessment by nursing indicated no ROM impairment, moderate ability to maintain standing balance and the resident's balance was not steady, but he/she able to stabilize without assistance.

The fall investigation on 8/6/15 stated the resident fell and hit his/her head when trying to get popcorn from the popcorn machine and was not using his/her walker at the time. The report stated the resident fell backwards and hit his/her head on the floor in the dining room. The investigation indicated the resident sustained a large bruise to the back of his/her head, with little bleeding noted, along with a 2 by 2 skin tear to his/her right 2nd finger. The report indicated staff provided wound care on the resident's head and finger wound. After the resident denied any pain and performed active ROM, the staff assisted him/her to a chair and reminded the resident (who had severe cognitive impairment) to use his/her walker and ask for help if needed.

The 8/9/15 at 2:14 PM, nurse's note indicated the resident had no changes in mental status and neurological status was intact. The note stated the resident ambulated with a walker, but was unsteady, and the staff encourage the resident to slow down. The note stated the resident knew limitations but chose not to follow them.

The 8/19/15 at 5:49 PM, nurse's note stated the staff called the nurse to the dining room where the resident was unresponsive and slouched over to the left side with his/her mouth wide open and gasping for air. The note indicated the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22	F 323		

was pale and diaphoretic (sweating), pulse weak and regular. The note indicated the resident appeared unresponsive to a sternal rub (hard rubbing on the chest over the heart).

The 8/19/15 at 5:55 PM, nurse's note indicated the resident opened his/her eyes and the staff transferred the resident from a chair to a wheelchair. The note indicated the resident's speech was short and unclear. At 6:00 PM, staff transferred him/her to the facility van and a nurse accompanied the resident to the hospital. At 6:17 PM, the note indicated the resident's family member stated when the resident left the clinic, after his/her appointment this afternoon, he/she didn't look good and his/her color wasn't right.

The 8/19/15 radiology report stated small subdural hematomas (bruising on the brain under the skull) could be acute (very sudden) or early sub-acute (recent onset).

The 8/19/15 care plan conference meeting note stated the resident was independent with dressing, grooming, toileting and personal hygiene. The note stated the resident ambulated independently with a walker, was a high risk for falls, and fell on 8/6/15 and hit his/her head. The note stated staff obtained a basket for the resident's walker to place his/her coffee cup in and encouraged him/her to keep the walker with him/her at all times.

The 8/22/15 at 2:25 PM, nurse's note stated the staff received a phone call from the hospital staff reporting the physician had diagnosed the resident with an acute, subdural hematoma from his/her fall on 8/6/15.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 23	F 323		

The 9/1/15 re-admission fall risk indicated high risk.

The 9/9/15 mobility assessment, by nursing, indicated the resident had no ROM impairment, moderate ability to maintain standing balance, and his/her balance was not steady but the resident was able to stabilize without assistance.

The 9/14/15 at 9:33 nurse's note indicated Housekeeper E observed the resident ambulate from his/her wheelchair to his/her bed and saw the resident fall and hit his/her head on the floor. The note stated the housekeeper stated the resident was up and ambulating without assistance. The note stated the resident could not remember what he/she was doing prior to the fall, and staff put alarms in place.

The 9/14/15 at 9:37 AM, nurse's note indicated staff notified the physician of the resident's fall and declining blood pressures . The note indicated at 8:30 the resident's blood pressure was 89/60 (optimal range is 110/70) and at 9:00 AM blood pressure was 70/55. The physician stated to monitor the resident and encourage fluids.

The 9/14/15 at 9:49 AM, nurse's note indicated the resident complained of his/her head hurting, but was unable to describe or rate his/her pain. The note indicated the resident refused Tylenol and stated " I think I need to see the doctor". Staff noted the resident very pale and made an appointment with his/her physician for 11:30 AM.

The 9/15/15 at 8:00 AM nurse's note stated the facility received the x-ray report of the right hip and right ribs, from the resident's fall on 9/14/15,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24	F 323		

and the report indicated no acute fracture of the hip and no definite acute displaced rib fracture.

On 9/15/15 at 3:44 PM, observation revealed staff brought the resident's alarm box to the maintenance person and stated the resident shut off the alarm box and then walked independently to the dining room. Observation revealed staff assisted the resident to get a beverage, and then sat with him/her while he/she did an activity.

On 9/16/15 at 7:30 AM, observation revealed the resident left the dining table, in his/her wheelchair and self-propelled from the dining room to his/her room. Further observation revealed the resident held a box of tissues in one hand and a cup of coffee in the other hand. Two staff came in to offer the resident help and 1 stayed to assist. The resident refused to allow staff to use the gait belt for the transfer and used the walker to stand and turn in front of the recliner. The resident stood tall with minimal unsteadiness and reached back and used the recliner arms to let him/herself down into the chair. The staff activated the chair alarm before leaving the room.

On 9/15/15 at 2:55 PM, the resident reported he/she fell when attempting to sit in the recliner without assistance. He/she stated he/she does not use the call light very much, even though staff encourage him/her to. The resident stated he/she was independent most of the time. The resident stated he/she had fallen before, but this fall hurt a lot worse and the staff took him/her to the (ER) Emergency Room to check for broken ribs.

On 9/15/15 at 4:10 PM, Nurse G verified the resident's initial care plan had not been completed and the comprehensive care plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25	F 323		

lacked individualized interventions to prevent further falls.

On 9/16/15 at 11:30 AM, Housekeeping Staff H stated he/she was in the dining room when the resident was getting some popcorn on 8/6/15. Housekeeping Staff H stated the resident was standing on a "little step stool", with no nursing staff in the area, lost his/her balance and fell, hitting his/her head on the floor and his/her hand/arm on the refrigerator.

On 9/16/15 at 2:00 PM, Housekeeping Staff E stated he/she was in the hall when the resident asked for some paper towels on 9/14/14. Housekeeping Staff E stated he/she heard the resident's walker fall and turned in time to see him/her on the floor, between bed one and his/her recliner. Housekeeping Staff E stated the resident had been up walking without his/her walker.

On 9/16/15 at 2:14 PM, Nurse A stated the resident was unsteady at times prior to the falls, got up without assistance a lot throughout the day and ambulated throughout the facility with his/her walker.

On 9/16/15 at 2:40 PM, Nurse Aide B stated after staff placed alarms on him/her, the resident figured out how to turn the alarms off. Nurse Aide B stated staff had placed an alarm that did not sound in the resident's room, but went directly to the pager system. He/she stated the alarm did not sound when the resident got up independently and ambulated to the dining room, and the staff found the alarm turned off again.

On 9/16/15 at 3:00 PM, Nurse C stated the resident was independent with a walker prior to a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

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F 323	Continued From page 26	F 323		

fall with head injury. He/she stated the resident was very unsteady now and used a wheelchair for mobility. Nurse C stated he/she had not observed any mental changes between the 8/7 fall and the 8/19 syncope (fainting) episode. Nurse C stated the resident's memory was poor and he/she attempted transfers on his/her own without calling for help.

On 9/16/15 at 5:25 PM, Administrative Nurse D verified the resident's care plan lacked individualized interventions for prevention of falls on the initial and comprehensive care plans prior to and after the resident's falls. Observation at this time revealed the "step stool", a 2 foot by 2 foot by 6 inch tall platform, under a desk in the director of nursing office. Administrative Nurse D reported staff moved the platform out of the dining room after the resident's fall.

The facility's 8/7/15 Falls and Fall Prevention policy stated staff would complete a fall risk assessment form on admission, quarterly, with a significant change and with each fall with interventions deemed appropriate put into place to minimize injuries. Interventions determined to be needed are to be put in place as soon as possible to protect the resident. The MDS coordinator will update the care plan. The policy stated the care plan would be reviewed with each fall and updated as needed. Accident/falls are to be reviewed for possible alternative safety measures by the risk manager and director of nursing.

The facility failed to provide individualized interventions to prevent falls for Resident #1, who fell and sustained a head injury 1 week after he/she was admitted to the facility and fell again

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	C 09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN COUNTY MANOR - LTCU	615 PRICE AVE OAKLEY, KS 67748

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F 323	Continued From page 27 on 9/14/15.	F 323		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: The facility had a census of 37 residents. The sample included 4 residents. Based on observation, record review and interview the facility failed to obtain physician ordered medications in a timely manner for 1 of 4 sampled residents. (#1) Findings included: - Resident #1's admission (MDS) Minimum Data	F 425		

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F 425	Continued From page 28	F 425		

Set assessment, dated 8/5/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident received antipsychotic and antidepressive medications.

The 8/5/15 (CAA) Care Area Assessment summary indicated the resident received Seroquel (antipsychotic medication) and Cymbalta (antidepressive medication).

The 7/30/15 care plan directed staff to administer medications as the physician ordered.

The 7/30/15 admission orders directed staff to administer, to the resident, the following medications:
Prednisone (anti-inflammatory), 5 (mg) milligram, daily.
Prilosec (decreases amount of stomach acid produced), 20 mg, daily.
Seroquel (antipsychotic), 25 mg, at bedtime.
Neurontin (medication used for nerve pain), three times daily.
Maalox Max suspension (antacid), 5 (ml) milliliters, before meals and at bedtime.

Review of the (MAR) Medication Administration Record and nurse's notes revealed no documentation the resident received the following medications between 7/31/15 and 8/7/15:
Prednisone, 5 mg, 7/31/15 through 8/7/15. (8 days, 8 doses)
Prilosec, 20 mg, 7/31/15 through 8/5/15. (6 days, 6 doses)
Seroquel, 25 mg, 7/31/15 through 8/4/15. (5 days, 5 doses)
Neurontin, 100 mg, 7/31/15 through 8/4/15 in the

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F 425	Continued From page 29	F 425		

afternoon. (5 days, 14 doses)
Maalox suspension, 5 ml, 7/31/15 through 8/7/15 at noon. (8 days, 30 doses)

On 9/16/15 at 7:30 AM, observation revealed the resident left the dining table, in his/her wheelchair and self-propelled from the dining room to his/her room.

On 9/16/15 at 5:25 PM, Administrative Nurse D verified staff had not administered the physician ordered doses of Neurontin, Prednisone, Seroquel, Maalox and Prilosec, as noted on the MAR. He/she stated the family wanted the facility to use the medications supplied by them, but kept forgetting to bring the medications to the facility. Administrative Nurse D stated staff failed to obtain the medication in a timely manner.

The facility failed to obtain the physician ordered medications for administration to Resident #1 during the first week after his/her admission to the facility.